

Metlifecare Limited - Highlands Hospital

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| Legal entity: | Metlifecare Limited |
| Premises audited: | Highlands Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 1 November 2018 End date: 2 November 2018 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 37 |

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

| Indicator | Description | Definition |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

| Indicator | Description | Definition |
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| Yellow | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
| Red | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

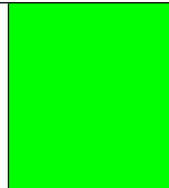
Metlifecare Limited - Highlands Hospital provides rest home and hospital level care for up to 41 residents. There is a village attached which has five apartments that are approved for rest home level care residents. To date, these five apartments have not been occupied by rest home level care residents and are not included in the number of beds reviewed. The service is operated by Metlifecare Limited and is managed by a nurse manager who reports to the village manager. The nurse manager is supported by a recently employed senior nurse who oversees clinical care provision.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, two contracted allied health providers and a general practitioner.

This audit identified four areas requiring improvements relating to medication management, activities, quality and risk evaluation documentation and call bell response times. Two previous areas requiring improvement relating to food services and human resources which had not been closed off prior to audit, as the due date was December 2018, have been fully addressed by the service and are now closed.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.



Standards applicable to this service fully attained.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

There were no residents at the time of audit who affiliate with their Maori culture. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of activities and maintains their links with the community.

The service has a medicines management policy and medicines are administered by staff who have an up to date medication competency.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Some standards applicable to this service partially attained and of low risk. |
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and bio medical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Security is maintained.

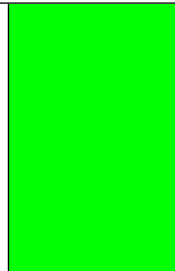
Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler was in use. Use of enablers is voluntary for the safety of residents in response to individual requests. No restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| Standards | 0 | 41 | 0 | 3 | 1 | 0 | 0 |
| Criteria | 0 | 89 | 0 | 3 | 1 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. The senior registered nurse interviewed stated that there is currently one resident with an advance directive care plan in place. Staff were observed to gain consent for day to day care.</p> |

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| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | <p>FA</p> | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The noticeboard in the lounge provides the names and contact details for the resident's advocate, kaumatua and pacific islander advocate based in the community, and support person for spiritual guidance.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | <p>FA</p> | <p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>FA</p> | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms are available in the lounge area.</p> <p>The complaints register reviewed showed that one complaint had been received since the previous audit in May 2018 and that actions taken, through to an agreed resolution, were documented and completed within the timeframes. An action plan showed any required follow up and improvements have been made where possible. The nurse manager is responsible for complaints management and follow up. Complaints are also recorded electronically and reviewed by the clinical quality and risk manager for the group. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided including the admission agreement and discussion with staff. The Code is displayed in the main foyer and lounge areas together with information on advocacy services, how to make a complaint and feedback forms.</p> |

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| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The senior registered nurse interviewed reported that there were no residents who affiliated with their Maori culture at the time of audit, and there were no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific Maori health plan; however, all values and beliefs of the resident would be integrated throughout the resident's long term care plans. There is acknowledgement of the Te Whare Tapa Wha model with input from cultural advisers within the local community as required to help support and develop a Maori health care plan for the resident. With the resident's consent a referral form is completed and sent to the local rohe for ongoing support. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p> |
| <p>Standard 1.1.7: Discrimination</p> | <p>FA</p> | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes</p> |

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| <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | | <p>education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p> |
| <p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included knocking on residents' doors before entering, day to day discussions and acknowledgement of families and friends visiting.</p> |
| <p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required to support the three residents who do not understand English due to the use of and regular visits of family members, communication cards, the use of an electronic translator device and the staff knowing the residents well. There were two residents acknowledged with a significant sensory impairment and appropriate equipment and resources were sighted and highlighted in residents' long-term care plans reviewed, for example, the use of a communication book, providing clear conversation and staff allowing time for the resident to respond, and support from external services, for example, speech language therapist.</p> <p>Each month an updated activities calendar is provided to each resident's room.</p> |
| <p>Standard 1.2.1: Governance The governing body of the</p> | <p>FA</p> | <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. At facility level, set goals reflect the organisation's strategic and</p> |

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| <p>organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | | <p>business plans. A sample of quarterly reports to the organisation's senior management team, who then report to the board of directors, showed adequate information to monitor performance. Reporting covers all aspects of service, including financial performance, quality data results, progress towards achieving set goals, complaints, staffing, emerging risks and issues.</p> <p>The care service is managed by a nurse manager who is a registered nurse with a current annual practising certificate and has been in the role for 10 months. The nurse manager has a direct reporting line to the village manager. Clinical care is overseen by a senior registered nurse. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through in-service education and off-site education, which includes attendance and training at Counties Manukau District Health Board meetings related to aged care, New Zealand Age Care Association conferences and leadership conferences.</p> <p>The service holds contracts with Counties Manukau District Health Board (CMDHB) for respite care, medical conditions and palliative care. Contracts held are Age Related Residential Care (ARRC), Community Residential Respite Services and Long Term Support-Chronic Health Conditions Residential and Respite. The CMDHB also offer Highlands Hospital primary options for acute care (POAC) residents. One POAC resident, seven rest home and 29 hospital residents were receiving services under the ARRC contract at the time of audit.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p> | <p>When the nurse manager is absent, the senior registered nurse, with support from the clinical quality and risk manager and the village manager, carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the nurse manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p> | <p>PA Low</p> | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident and family satisfaction survey, clinical incidents including infections, falls, wounds and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the senior management team meetings, registered nurse meetings and staff meetings. Staff reported their involvement in quality and risk management activities</p> |

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| <p>principles.</p> | | <p>through audit activities and the implementation of corrective actions. Corrective actions are developed and implemented to address any shortfalls. Evaluation of the corrective actions put in place is not consistently documented to show outcomes.</p> <p>Resident and family satisfaction surveys are completed annually. The 2018 survey showed that the service gained an 85% overall satisfaction rating. A corrective action plan sighted showed that all topics that gained less than 85% have documented corrective actions. Staff meeting minutes identified that this had been discussed at the October 2018 meeting, but the nurse manager confirmed that the corrective actions have yet to be actioned.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the nurse manager, who enters the data electronically onto a data base which is viewed by the clinical quality and risk manager. The resident's family and the GP are notified of incidents and accidents as appropriate. Analysed information is shared with all staff as confirmed in staff meeting minutes reviewed.</p> <p>The nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests, issues based audits or public health notifications since the previous audit.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p> | <p>FA</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> |

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| <p>accordance with good employment practice and meet the requirements of legislation.</p> | | <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and then annually. All the staff files reviewed had completed orientation and processes. This was an area not closed off by the DHB prior to audit but has been fully addressed by the service to meet the requirements of the standard.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member who is employed as a group educator is the internal assessor for the programme and also provides in-service education and helps to develop the training calendar. There are sufficient trained and competent registered nurses (five) who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals for interRAI.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of six-weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p> <p>The nurse manager and senior registered nurse work Monday to Friday and share the on-call component. There is dedicated cleaning staff seven days a week and laundry staff cover six days a week. An administration assistant works Monday to Friday along with a full-time maintenance person. A night porter, who covers night security for the whole facility including the village, seven nights a week. Kitchen staff are all employed by the village.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</p> | <p>FA</p> | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the</p> |

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| <p>current, confidential, and accessible when required.</p> | | <p>entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | <p>FA</p> | <p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed communication between the facility, family and acute hospital setting and the required supporting documentation. Family of the resident reported being kept well informed during the transfer of their relative.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>PA Moderate</p> | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management; however, safe disposal of a used needle administered by a registered nurse did not occur on the day of audit. All staff who administer medicines are competent to perform the function they manage.</p> |

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| | | <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. The facility does not store vaccines on site.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The medication electronic device showed that for 16 residents their three-monthly GP review was not up to date. The 16 residents' files were reviewed, and evidence was sighted to show that the GP reviews were up to date and all the residents had been seen by the GP. Standing orders are not used.</p> <p>There was one resident self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>The food service is provided on site by the village chef manager, three other chefs and a kitchen team, and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. The kitchen was recently audited by the Auckland Council and was awarded an A for excellent (100%) grade. Registration was issued and expires July 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef manager and cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>The previous audit identified an area for an improvement to ensure that the kitchenette fridges stored food as per requirements and fridge temperatures are recorded and followed up if outside of recommended guidelines. The corrective action is now addressed and observations at the time of audit and records were available to demonstrate this.</p> |

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| | | <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The cook interviewed stated that they can manage all menus and different food diets for all residents.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. There is a copy of the day's menu on each of the dining room tables and care staff were observed to read the menu to residents sitting at the table. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided with the option of residents having their meals in their bedrooms.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All but three residents have current interRAI assessments completed by one of five trained interRAI assessors on site which includes the senior registered nurse. Two residents have been admitted within the last five days and one resident has been admitted short term under the primary options for acute care (POAC). Residents and families confirmed their involvement in the assessment process.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Activity care plans do not always identify specific goals and interventions for residents (see criterion 1.3.7.1).</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in</p> |

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| | | <p>the development and ongoing evaluation of care plans.</p> <p>The facility has a wound management and pressure injury care policy that was last reviewed in 2018. At the time of audit, there were three residents with pressure injuries. Residents wound care plans identified all interventions, equipment and resources required and in place.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision, except in the case of documentation of activity care planning (Refer criterion 1.3.7.1). The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | PA Low | <p>The activities programme is overseen by a trained occupational therapist. The occupational therapist visits the facility five hours per week and is available by phone when required. The residents are supported by a caregiver whom has taken on the interim role of activities co-ordinator as this role was being advertised at the time of audit. The residents are supported Monday to Friday three hours per day.</p> <p>Residents' activities assessments are reviewed to help formulate an activities programme that is meaningful to the residents. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Staff encourage all residents to attend activities in the main lounge area. Residents who are independently mobile attend activities in the village, with two residents currently attending the weekly exercise and hydrotherapy sessions held by the contracted physiotherapist.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. The resident satisfaction survey showed an increase in satisfaction from 69% in 2017 to 81% of residents satisfied or very satisfied with the programme. Residents interviewed confirmed they find the programme appropriate; however, not all resident activity plans identify goals and interventions and/or evaluations.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans</p> | FA | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> |

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| <p>are evaluated in a comprehensive and timely manner.</p> | | <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. Residents' activity care plans did not always document evaluations (see criterion 1.3.7.1).</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | <p>FA</p> | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the wound nurse specialist and dietician. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>A current building warrant of fitness (expiry date 09 March 2019) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> |

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| | | <p>External areas are safely maintained and are appropriate to the resident groups and setting. The care facility is on the first floor and there are two lifts and stairs available for residents and visitor use to get to the ground floor. The outdoor gardens are well set out with shaded seating areas throughout.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned. Documentation sighted confirmed this. Residents and family members interviewed stated they are happy with the environment.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes one bedroom with full ensuite facilities and 19 bedrooms with toilet facilities. All bedrooms have hand basins. Full bathroom facilities are located centrally in each wing. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>Water temperatures are maintained at below 45oC to ensure residents' safety and to meet building compliance standards.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. There are three couples who are happy having single rooms and they undertake daily tasks such as activities and dining together. Rooms are personalised with furnishings, photos and other personal items displayed. Residents confirmed during interview that they are happy with their rooms and that they are of adequate size.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff confirmed they can easily use lifting aids when required.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> |

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| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | <p>FA</p> | <p>Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. One laundry staff member interviewed stated that not all residents clothing is labelled. This information was passed onto the nurse manager during the audit. Staff meeting minutes identify this has been discussed at several meetings and all staff need to take responsibility for informing the laundry staff if they find unlabelled clothing. The caregivers stated that if they notice that an item of clothing is not labelled, they place this in a clear plastic bag and take it to the laundry for labelling.</p> <p>There is a small designated cleaning team who have received appropriate training. As confirmed in interview of cleaning staff and training records, all cleaning staff have completed safe chemical handling training. Chemicals were securely stored and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the monthly check of detergent use by the supplier. A report for this is left at the facility.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>PA Low</p> | <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 27 July 2002. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service; the most recent being on 4 September 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 41 residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. When the call bell response times were check for September and October 2018 documentation showed that response times were up to 29 minutes. Staff meeting minutes showed that staff had been reminded to turn off the call bell when they answer them.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the night porter undertakes nightly security checks of the premises.</p> |

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| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | <p>FA</p> | <p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Thirty-nine bedrooms have a ranch slider onto a Juliette balcony. Heating is provided by electric wall mounted thermostat control heaters in residents' rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | <p>FA</p> | <p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP and pharmacist. The infection control programme and manual are reviewed two yearly.</p> <p>The senior registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the nurse manager and tabled at the quality/risk committee meeting. This committee includes the nurse manager, clinical quality and risk manager, infection control/senior registered nurse, kitchen manager and representatives from care, household and maintenance staff.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | <p>FA</p> | <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since August 2018. She has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p> | <p>FA</p> | <p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2018 and included appropriate referencing.</p> |

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| <p>procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | | <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |
| <p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p> |
| <p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>FA</p> | <p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/senior registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the nurse manager and reported to the organisation. Eighty percent (80%) of residents and 44% of staff in April 2018 consented to the flu vaccine</p> <p>The facility has had a total of 30 infections since April 2018 through to and including September 2018. Surveillance data did not identify any residents who had frequent infections, however residents have been identified with an increased risk of infections due to co-morbidities. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked internally within the group and externally three-monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> |

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| | | There have been no infection outbreaks in the last 12 months. |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator (RN) provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, there was one resident who had a bedside rail as an enabler. This is only used intermittently, and the resident decides on a nightly basis if they wish staff to pull the bedrail up. Consent was sighted in the resident's file along with an assessment and GP approval. This is reviewed six monthly as clearly documented in the restraint register. Enablers, which were the least restrictive and used voluntarily at the request of the resident are managed according to policy.</p> <p>No residents were using restraints. Policy states that restraint is used as a last resort when all alternatives have been explored. Restraint processes are clearly understood by the staff interviewed. Annual education is undertaken and is part of the orientation process for all new staff.</p> |

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | PA Low | <p>Quality improvement data are collected and analysed. Information is communicated to staff and where appropriate residents and/or family members, such as complaints follow-up. The evaluation of corrective actions put in place is not consistently documented to show that the required outcomes have been achieved. For example, no documented outcome related to the length of time to respond to call bell following ongoing staff education. Refer comments in 1.4.7.5.</p> | <p>Quality improvement data evaluation is not consistently documented to identify if corrective actions put in place have improved service outcomes.</p> | <p>Provide evidence that quality data evaluation is consistently documented to show outcome results.</p> <p>90 days</p> |

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| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | <p>PA Moderate</p> | <p>The registered nurse has been assessed as being medication competent. When interviewed the registered nurse could recall the proper procedures required when administering and supporting residents with medication. At time of audit the medication trolley was observed after lunch time medications to have a used syringe with an unsheathed needle (needle pointing down) in a box on the medication trolley. The syringe was disposed of immediately in the syringe container on the medication trolley. An incident form was completed, and a discussion was had with the clinical quality and risk manager and registered nurse. There is no history of this error occurring and learnings have been discussed with the nursing team to reduce and minimise the risk of this incident occurring again.</p> | <p>A used unsheathed syringe was found on the medication trolley during audit review.</p> | <p>Provide evidence that all medication actions reflect best medication guidelines and safe practice.</p> <p>1 days</p> |
| <p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | <p>PA Low</p> | <p>All residents' files reviewed had an initial activity assessment completed. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement and satisfaction in the assessment process and activities provided. The sample of residents' files reviewed was extended to include a further two files. Eight of eight residents' activity plans did not have individualised activity goals or interventions identified that were specific and meaningful to the resident. Six of the eight activity plans did not show evaluations of the activities for the resident.</p> | <p>Residents' individual activity plans do not consistently identify meaningful activity goals and interventions. Plans that do have goals or interventions do not always have documented evaluations.</p> | <p>Provide evidence that activity plans are meaningful for individual residents and that goals and interventions are evaluated.</p> <p>180 days</p> |
| <p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance</p> | <p>PA Low</p> | <p>The service has an appropriate call system available to all residents. Staff carry pagers which alert them to which area the call bell has been activated. The monitoring of call bell response times is undertaken by an off-site company who regularly report to the nurse manager. The electronic data sent to the nurse manager identifies the time it has</p> | <p>Regular monthly call bell audit printed off data identifies that response times are up to 29 minutes. The nurse</p> | <p>Provide evidence that call bell response times are</p> |

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| when required. | | taken to turn off the call bell. Response times sighted for September and October 2018 vary from less than one minute to 29 minutes. The service is aware this is an issue and staff have been reminded to turn off the call bells when they respond. The nurse manager has not received any concerns or complaints about the length of time it is taking staff to respond to call bells and feels the audit data is a reflection of staff forgetting to turn the bell off when they first respond. | manager verbally confirmed this has been addressed and it was confirmed in staff meeting minutes sighted. There was no change in the response times noted following the staff discussion. | timely. 60 days |
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.